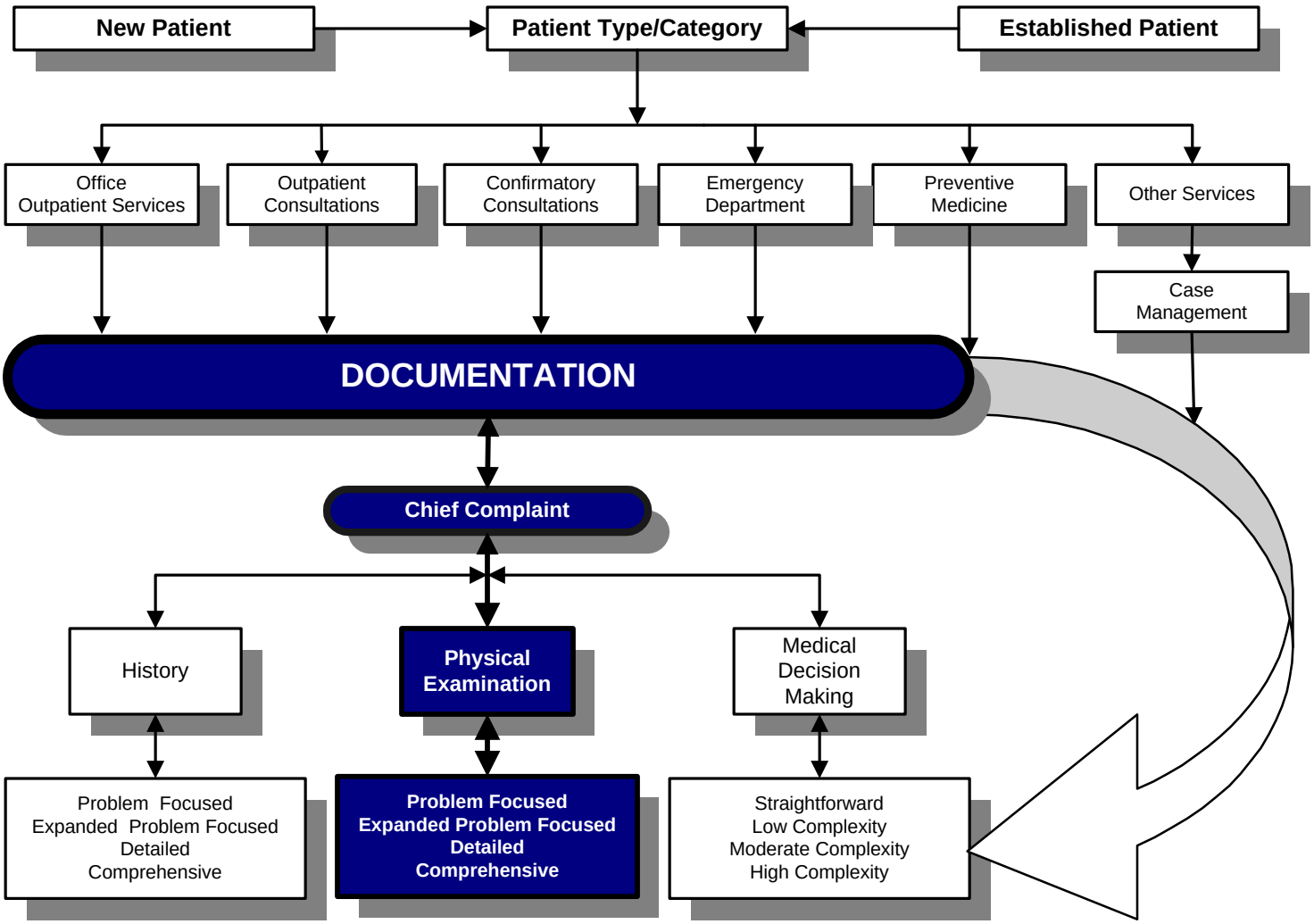
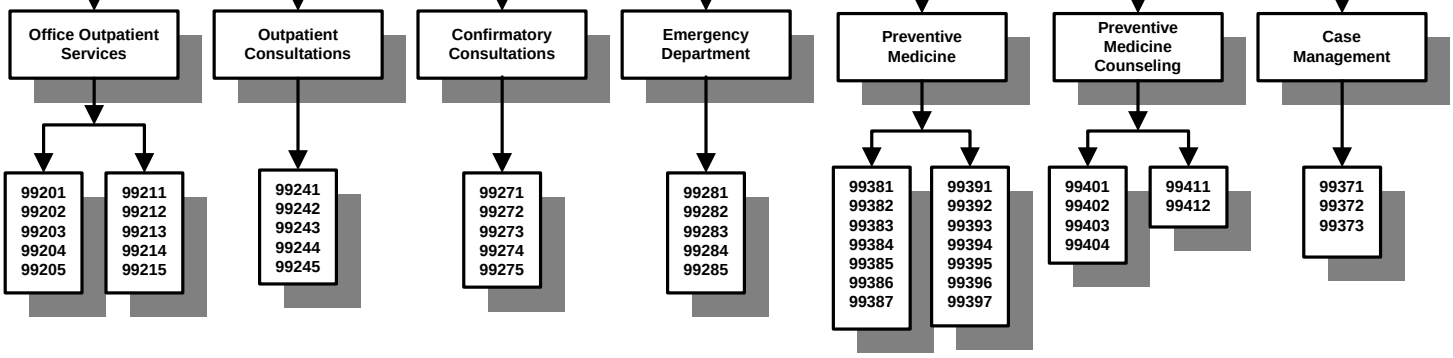
EVALUATION AND MANAGEMENT FLOWCHART



EVALUATION AND MANAGEMENT CPT CODES



CPT Evaluation and Management, Physical Examination

METHODOLOGY

The physical examination section provides detailed documentation requirements to accurately reflect the physicians' level of effort. The chief complaint and to some degree, the history, will influence the extent of the physical examination.

OBJECTIVES

Upon completion of the Physical Examination section you will be able to:

- Identify physical examination single organ systems and body areas;
- Define the types of physical examination:
  - Problem focused,
  - Expanded problem focused,
  - Detailed, and
  - Comprehensive; and
- Select the type of examination based on documentation.

DEFINITIONS

Terms defined in this section include:

- Single organ systems,
- Body areas, and
- Levels of physical examination.

The following worksheet is designed to display abbreviated elements specific to the General Multi-System examination. Each component of the following chart is explained in detail in the following pages.

General Multi-System Examination

Constitutional
- Vital Signs (3)
  - BP ↑/↓ — Temp
  - BP → — Height
  - Pulse RR — Weight
  - Respiration
- General Appearance

Gastrointestinal
- Abd Exam: Mass/Tenderness
- Liver & Spleen Exam
- Hernia Exam
- Anus, Perineum & Rectum Exam
- Stool Occult (Indicated)

ENMT
- Inspect External Ears & Nose
- Aud Canal & Tymp Membr Exam
- Assess Hearing
- Inspect Nasal Mucosa, Sept & Turb
- Inspect Lips, Teeth & Gums
- Oropharynx Exam

Cardiovascular
- Palpation Heart
- Auscultation Heart
- Carotid Arteries
- Abdominal Aorta
- Femoral Arteries
- Pedal Pulses
- Extremities

Respiratory
- Respiratory Effort
- Percussion Chest
- Palpation Chest
- Auscultation Lungs

Skin
- Inspect Skin & Sub-q Tiss
- Palpate Skin & Sub-q Tiss

Lymphatic
- Palp Lymph Nodes 2 or >
  - Neck — Groin
  - Axillae — Other

Neurological
- Test Cranial Nerves
- DTR Exam
- Sensation Exam

Eyes
- Insp Conjunc & Lids
- Pupil & Iris Exam
- Optic Disc Exam

Genitourinary

Male
- Scrotum
- Penis
- Prostate

Female
- Genitalia — Cervix
- Urethra — Uterus
- Bladder — Adnexa

Musculoskeletal
- Gait & Station
- Inpect/Palp Digits & Nails
- Joints, Bones & Muscles 1 or > of 6 areas
  - Inspect/Palpate — Stability
  - ROM — Musc Strength & Tone

Psychiatric
- Judgement & Insight — Memory
- Orientation TPP — Mood & Affect

Neck
- Neck Exam
- Thyroid Exam

Chest/Breast
- Inspect Breasts
- Palp Breast & Axilla

Type of Examination

Perform and Document:

- **Problem Focused: 1-5 bulleted (•) elements**
- **Expanded Problem Focused: 6 or > bulleted (•) elements**
- **Detailed: 2 or > bulleted (•) elements of 6 systems or 12 or > bulleted (•) elements in 2 or > systems**
- **Comprehensive: Perform all elements identified by a bullet (•) in at least 9 organ systems/body areas and document at least 2 bulleted (•) elements from each of 9 systems/areas**

CPT Evaluation and Management, Physical Examination

Physical Examination

Physical examination is defined as an assessment of the body by auscultation, palpation, percussion, and inspection. A general multi-system and eleven (11) single organ system examinations have been defined by HCFA and are recognized by CPT for purposes of describing physical examinations. The single organ systems include:

- "Cardiovascular
- Ears, Nose, Mouth, and Throat
- Eyes
- Genitourinary (Female)
- Genitourinary (Male)
- Hematological/Lymphatic/Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

CPT has defined seven (7) physical examination body areas, in addition to the single organ systems. CPT physical examination body areas include the following:

- "Head, including the face,
- Neck,
- Chest, including breasts and axilla,
- Abdomen,
- Genitalia, groin, buttocks,
- Back, and
- Each extremity." [31]

HCFA and the American Medical Association (AMA) developed guidelines to provide physicians with recommendations for medical record documentation, and application of E/M services consistent with CPT definitions. Documentation guidelines for the physical examination include:

- "Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ systems(s) should be documented. A notation of "abnormal" without elaboration is insufficient. The abnormal finding should be addressed in documentation.
- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.
- A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s)."[32]

"A physician may perform a general multi-system examination or a single organ system examination regardless of specialty. The type (general multi-system or single organ system) and content of examination are selected by the examining physician; and are based upon clinical judgement, the patient's history, and the nature of the presenting problem(s)."[33]

[31] Kirschner, 2000, p. 7
[32] HCFA, p. 11
[33] Ibid., p. 10

CPT Evaluation and Management, Physical Examination

Types of Physical Examination

The following table displays CPT coding definitions and provides corresponding HCFA guidelines for the types of physical examinations including: problem focused, expanded problem focused, detailed, and comprehensive. Column two (2) of the table displays the CPT E/M coding definitions. The CPT terminology is flexible and based on the individual physician's interpretation. However, HCFA has provided greater clinical specificity; and has placed values on the amount of effort in performing an examination e.g., one (1) to five (5) elements.

Types of Physical Examination	CPT E/M Coding Definitions[34]	General Multi-System HCFA Definitions[35]	Single Organ System HCFA Definitions[36]
Problem Focused	A limited examination of the affected body area or organ system.	Includes performance and documentation of one (1) to five (5) elements identified by a bullet in one (1) or more organ system(s)/body area(s).	Includes performance and documentation of one (1) to five (5) elements identified by a bullet, whether in a shaded box or in a box without shading.
Expanded Problem Focused	A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).	Includes performance and documentation of at least six (6) elements identified by a bullet in one (1) or more organ system(s)/body area(s).	Includes performance and documentation of at least six (6) elements identified by a bullet, whether in a shaded box or in a box without shading.
Detailed	An extended examination of the affected body area(s) and other symptomatic or related organ system(s).	Includes at least six (6) organ systems/body areas. For each system/area selected, performance and documentation of at least two (2) elements identified by a bullet is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve (12) elements identified by a bullet in two (2) or more organ systems/body areas.	Includes performance and documentation of at least twelve (12) elements identified by a bullet, whether in a shaded box or in a box without shading. ***Eye and/or Psychiatric Examination***: Includes performance and documentation of at least nine (9) elements identified by a bullet, whether in a shaded box or in a box without shading.
Comprehensive	A general multi-system examination, or complete examination of a single organ system.	Includes at least nine (9) organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. Documentation of at least two (2) elements identified by a bullet for each area/system is expected.	Includes performance of all elements identified by a bullet, whether in a shaded box or in a box without shading. Documentation of every element in each shaded box and at least one (1) element in each box without shading is expected.

"**Note**: The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and risk factors identified."[37]

[34] Kirschner, 2000, p. 7
[35] HCFA, 1997, pp. 11-12
[36] Ibid., pp. 12-13
[37] Kirschner, 2000, p. 7

Types of Physical Examination (Continued)

To further explain the concept for applying physical examination elements, the following tables were added to provide clarification for each of the eleven (11) single organ systems and the general multi-system examination. For each type of examination, there are two (2) tables. Each table is numbered and followed by an A or B.

- Table A defines the detailed elements for the examination. The left-hand side of the table lists the system/body areas. The right-hand side provides a detailed explanation of the elements of examination.

- Table B is the worksheet/table with an abbreviated list of elements by body system. Each system/body area is listed and is underlined. For example, the General Multi-System displays "Constitutional" which contains two (2) elements e.g., vital signs and general appearance of the patient. If both of these elements are performed and documented, it counts as two (2) elements. Documentation of five (5) elements meets criteria for a "Problem Focused" physical examination, etc. As you view each table, you will note all body systems, except the General Multi-System, contain gray shaded boxes. Every element listed in the shaded box must be documented for the review type to be a comprehensive examination. See Table II-A and II-B for examples.

CPT Evaluation and Management, Physical Examination

General Multi-System Examination

The level of physical examination is based on the sum of physical examination elements performed and documented. Documentation elements for the general multi-system examination are found in Table I-A. Table I-B is a worksheet containing abbreviated general multi-system physical examination elements.

Table I-A[38]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff.) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Inspection of conjunctivae and lids • Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry) • Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, or hemorrhages)
Ears, Nose, Mouth, and Throat	• External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses) • Otoscopic examination of external auditory canals and tympanic membranes • Assessment of hearing (e.g., whispered voice, finger rub, tuning fork) • Inspection of nasal mucosa, septum, and turbinates • Inspection of lips, teeth, and gums • Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils, and posterior pharynx
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (e.g., dullness, flatness, hyperresonance) • Palpation of chest (e.g., tactile fremitus) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Palpation of heart (e.g., location, size, thrills) • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of carotid arteries (e.g., pulse amplitude bruits) • Examinations of abdominal aorta (e.g., size bruits) • Examination of femoral arteries (e.g., pulse amplitude bruits) • Examination of pedal pulses (e.g., pulse amplitude) • Examination of extremities for edema and/or varicosities
Chest/Breasts	• Inspection of breasts (e.g., symmetry nipple discharge) • Palpation of breasts and axillae (e.g., masses, lumps, tenderness)
Gastrointestinal/ Abdomen	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Examination for presence or absence of hernia. • Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, or rectal masses • Obtain stool sample for occult blood test when indicated

Table I-A is continued on the next page.

[38] HCFA, 1997, pp. 13-16

CPT Evaluation and Management, Physical Examination

General Multi-System Examination Table I-A (Continued)

System/Body Area	Elements of Examination
Genitourinary	**Male**: • Examination of scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass) • Examination of penis • Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness) **Female**: Pelvic examination (with or without specimen collection for smears and cultures) including: • Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Examination of urethra (e.g., masses, tenderness, scarring) • Examination of bladder (e.g., fullness, masses, tenderness) • Cervix (e.g., general appearance, lesions, discharge) • Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent, or support) • Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)
Lymphatic	Palpation of lymph nodes **in two (2) or more** areas: • Neck • Axillae • Groin • Other
Musculoskeletal	• Examination of gait and station. • Inspection and/or palpation of digits and nails e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes Examination of joints, bones, and muscles of **one (1) or more of the following six (6)** areas: (1) head and neck; (2) spine, ribs, and pelvis; (3) right upper extremity; (4) left upper extremity; (5) right lower extremity; and (6) left lower extremity. Examination of a given area includes: • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of range of motion with notation of any pain, crepitation, or contracture. • Assessment of stability with notation of any dislocation-(luxation), subluxation, or laxity. • Assessment of muscle strength and tone (e.g., flaccid, cogwheel, spastic) with notation of any atrophy or abnormal movements
Skin	• Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers) • Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)
Neurological	• Test cranial nerves with notation of any deficits • Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski) • Examination of sensation (e.g., by touch, pin, vibration, proprioception)
Psychiatric	• Description of patient's judgment and insight Brief assessment of mental status including: • Orientation to time, place, and person • Recent and remote memory • Mood and affect (e.g., depression, anxiety, agitation)

CPT Evaluation and Management, Physical Examination

Table I-B

General Multi-System Examination

Constitutional
- Vital Signs (3)
  - BP ↑/↓
  - BP →
  - Pulse RR
  - Respiration
  - Temp
  - Height
  - Weight
- General Appearance

Gastrointestinal
- Abd Exam: Mass/Tenderness
- Liver & Spleen Exam
- Hernia Exam
- Anus, Perineum & Rectum Exam
- Stool Occult (Indicated)

ENMT
- Inspect External Ears & Nose
- Aud Canal, & Tymp Membr Exam
- Assess Hearing
- Inspect Nasal Mucosa, Sept & Turb
- Inspect Lips, Teeth & Gums
- Oropharynx Exam

Cardiovascular
- Palpation Heart
- Auscultation Heart
- Carotid Arteries
- Abdominal Aorta
- Femoral Arteries
- Pedal Pulses
- Extremities

Respiratory
- Respiratory Effort
- Percussion Chest
- Palpation Chest
- Auscultation Lungs

Skin
- Inspect Skin & Sub-q Tiss
- Palpate Skin & Sub-q Tiss

Lymphatic
- Palp Lymph Nodes 2 or >
  - Neck
  - Groin
  - Axillae
  - Other

Neurological
- Test Cranial Nerves
- DTR Exam
- Sensation Exam

Eyes
- Insp Conjunc & Lids
- Pupil & Iris Exam
- Optic Disc Exam

Genitourinary

Male
- Scrotum
- Penis
- Prostate

Female
- Genitalia
- Urethra
- Bladder
- Cervix
- Uterus
- Adnexa

Musculoskeletal
- Gait & Station
- Inspect/Palp Digits & Nails
- Joints, Bones & Muscles 1 or > of 6 areas
  - Inspect/Palpate
  - Stability
  - ROM
  - Musc Strength & Tone

Psychiatric
- Judgement & Insight
- Memory
- Orientation TPP
- Mood & Affect

Neck
- Neck Exam
- Thyroid Exam

Breast
- Inspect Breasts
- Palp Breast & Axilla

Perform and Document:

Problem Focused: 1-5 bulleted (▪) elements.

Expanded Problem Focused: 6 or > bulleted (▪) elements.

Detailed: 2 or > bulleted (▪) elements of 6 systems OR 12 or > bulleted (▪) elements in 2 or > systems.

Comprehensive: Perform all elements identified by a bullet (€) in at least 9 organ systems/body areas and document at least 2 bulleted (▪) elements from each of 9 systems/areas.

CPT Evaluation and Management, Physical Examination

Cardiovascular Examination

The cardiovascular examination documentation elements are found in Table II-A. Table II-B is a worksheet containing abbreviated cardiovascular physical examination elements.

Table II-A [39]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Inspection of conjunctivae and lids (e.g., xanthelasma)
Ears, Nose, Mouth, and Throat	• Inspection of teeth, gums, and palate • Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	• Examination of jugular veins (e.g., distension; a, v, or cannon a waves) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Palpation of heart (e.g., location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) • Auscultation of heart including sounds, abnormal sounds, and murmurs • Measurement of blood pressure in two (2) or more extremities when indicated (e.g., aortic dissection, coarctation) • Examination of carotid arteries (e.g., waveform, pulse amplitude, bruits, apical-carotid delay) • Examination of abdominal aorta (e.g., size bruits) • Examination of femoral arteries (e.g., pulse amplitude bruits) • Examination of pedal pulses (e.g., pulse amplitude) • Examination for peripheral edema and/or varicosities
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Musculoskeletal	• Examination of the back with notation of kyphosis or scoliosis • Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs • Assessment of muscle strength and tone (e.g., flaccid, cogwheel, spastic) with notation of any atrophy and abnormal movements
Extremities	• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., stasis dermatitis, ulcers, scars, xanthomas)
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

[39] HCFA, 1997, pp. 18-19

CPT Evaluation and Management, Physical Examination

Table II-B

Cardiovascular Examination

Constitutional
- Vital Signs (3)
  - BP ↑/↓
  - BP →
  - Pulse RR
  - Respiration
  - Temp
  - Height
  - Weight
- General Appearance

Gastrointestinal
- Abd Exam: Mass/Tenderness
- Liver & Spleen Exam
- Stool Occult (Indicated)

ENMT
- Inspect Teeth, Gums & Palate
- Inspect Oral Mucosa
  Note Pallor/Cyanosis

Cardiovascular
- Palpation Heart
- Auscultation Heart
- BP 2 or > Extremities
- Carotid Arteries
- Abdominal Aorta
- Femoral Arteries
- Pedal Pulses
- Extremities: Peripheral Edema & Varicosities

Musculoskeletal
- Back Exam: Kyphosis/Scoliosis
- Examine Gait/Ability to Exercise
- Assess Muscle Strength & Tone

Eyes
- Inspect Conjunctivae & Lids

Respiratory
- Respiratory Effort
- Auscultation Lungs

Extremities
- Inspect & Palpate Digits & Nails

Neck
- Jugular Vein Exam
- Thyroid Exam

Skin
- Inspect & Palpate Skin & Sub-q Tissue

Neuro/Psych

Brief MSE:
- Orientation Time, Place & Person
- Mood & Affect

Perform and Document:

Problem Focused: 1-5 bulleted (▪) elements.

Expanded Problem Focused: 6 or > bulleted (▪) elements.

Detailed: 12 or > bulleted (▪) elements.

Comprehensive: Perform all elements identified by a bullet (€); document all elements in each shaded box and at least 1 element in each unshaded box.

CPT Evaluation and Management, Physical Examination

Ears, Nose, and Throat Examination

Documentation elements for the ears, nose, and throat (ENT) examination are found in Table III-A. Table III-B is a worksheet containing abbreviated ENT physical examination elements.

Table III-A[40]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) • Assessment of ability to communicate (e.g., use of sign language or other communication aids) and quality of voice
Head and Face	• Inspection of head and face (e.g., overall appearance, scars, lesions, and masses) • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness • Examination of salivary glands • Assessment of facial strength
Eyes	• Test ocular motility including primary gaze alignment
Ears, Nose, Mouth, and Throat	• Otoscopic examination of external auditory canals and tympanic membranes including pneumo-otoscopy with notation of mobility of membranes • Assessment of hearing with tuning forks and clinical speech reception thresholds (e.g., whispered voice finger rub) • External inspection of ears and nose (e.g., overall appearance, scars, lesions, and masses) • Inspection of nasal mucosa, septum, and turbinates • Inspection of lips, teeth, and gums • Examination of oropharynx; oral mucosa, hard and soft palates, tongue, tonsils, and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces) • Inspection of pharyngeal walls and pyriform sinuses (e.g., pooling of saliva, asymmetry, lesions) • Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords, or mobility of larynx (Use of mirror not required in children) • Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae, and Eustachian tubes (Use of mirror not required in children)
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Inspection of chest including symmetry, expansion, and/or assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination for peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Neurological/ Psychiatric	• Test cranial nerves with notation of any deficits Brief assessment of mental status including: • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

[40] HCFA, 1997, pp. 20-21

CPT Evaluation and Management, Physical Examination

Table III-B

Ears, Nose, and Throat Examination

Constitutional
- Vital Signs (3)
  BP ↑/↓ Temp
  BP→ Height
  Pulse RR Weight
  Respiration
- General Appearance
- Ability to Communicate

Head and Face
- Inspect Head & Face
- Palpate & Percussion Face
- Salivary Glands Exam
- Assess Facial Strength

Lymphatic
- Palpate Lymph Nodes
- Neck
- Groin
- Axillae
- Other

ENMT
- Otoscopic Exam: Auditory Canals & Tympanic Membranes
- Assess Hearing with Tuning Forks & Clinical Speech Reception
- Inspect External Ears & Nose
- Inspect Nasal Mucosa, Septum & Turbinates
- Inspect Lips, Teeth & Gums
- Oropharynx Exam: Mucosa, Palates, Tongue, Tonsils & Posterior Pharynx
- Inspect Pharyngeal Walls & Pyriform Sinuses
- Mirror Exam of Larynx
- Mirror Exam of Nasopharynx

Neck
- Neck Exam
- Thyroid Exam

Eyes
- Test Ocular Motility including Primary Gaze Alignment

Respiratory
- Inspection Chest
- Auscultation Lungs

Cardiovascular
- Auscultation Heart
- Peripheral Vascular Exam

Neuro/Psych
- Test Cranial Nerves

Brief MSE:
- Orientation Time, Place & Person
- Mood & Affect

Perform and Document:

Problem Focused: 1-5 bulleted (▪) elements.

Expanded Problem Focused: 6 or > bulleted (▪) elements.

Detailed: 12 or > bulleted (▪) elements.

Comprehensive: Perform all elements identified by a bullet (▪); document all elements in each shaded box at least 1 element in each unshaded box.

CPT Evaluation and Management, Physical Examination

Eye Examination

Eye examination documentation elements are found in Table IV-A. Table IV-B is a worksheet containing abbreviated eye examination elements.

Table IV-A[41]

System/Body Area	Elements of Examination
Eyes	• Test visual acuity (Does not include determination of refractive error.) • Gross visual field testing by confrontation • Test ocular motility including primary gaze alignment • Inspection of bulbar and palpebral conjunctivae • Examination of ocular adnexae including lids (e.g., ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits, and preauricular lymph nodes • Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), and size (e.g., anisocoria) and morphology • Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film • Slit lamp examination of the anterior chambers including depth, cells, and flare • Slit lamp examination of lenses including clarity, anterior and posterior capsule, cortex, and nucleus • Measurement of intraocular pressures (except in children and patients with trauma or infectious disease) Ophthalmoscopic examination through dilated pupils (unless contraindicated) of: • Optic discs including size, C/D ratio, appearance (e.g., atrophy, cupping, tumor elevation) and nerve fiber layer • Posterior segments including retina and vessels (e.g., exudates and hemorrhages)
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

[41] HCFA, 1997, pp. 23-24

CPT Evaluation and Management, Physical Examination

Table IV-B

Eye Examination	
Eyes • Test Visual Acuity • Gross Visual Field Testing by Confrontation • Test Ocular Motility including Primary Gaze Alignment • Inspection of Bulbar & Palpebral Conjunctivae • Examination of Ocular Adnexae • Examination of Pupils and Irises • Slit Lamp Examination of Corneas • Slit Lamp Examination of Anterior Chambers • Slit Lamp Examination of Lenses • Measurement of Intraocular Pressures (except in children and patients with trauma/infectious disease) Ophthalmoscopic Exam through Dilated Pupils (unless contraindicated): • Optic Discs • Posterior Segments	**Neuro/Psych** Brief MSE: • Orientation Time, Place & Person • Mood & Affect

Perform and Document:
Problem Focused: 1-5 bulleted (•) elements.
Expanded Problem Focused: 6 or > bulleted (•) elements.
Detailed: 9 or > bulleted (•) elements.
Comprehensive: Perform all elements identified by a bullet (•); document all elements in each shaded box and at least 1 element in each unshaded box.

CPT Evaluation and Management, Physical Examination

Male Genitourinary Examination

The male genitourinary examination elements are found in Table V-A. Table V-B is a worksheet containing abbreviated male genitourinary physical examination elements.

Table V-A[42]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff.) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination for peripheral vascular system by observation (e.g., swelling or varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination for presence or absence of hernia • Examination of liver and spleen • Obtain stool sample for occult blood test when indicated
Genitourinary	**MALE:** • Inspection of anus and perineum Examination (with or without specimen collection for smears and cultures) of genitalia including: • Scrotum (e.g., lesions, cysts, rashes) • Epididymides (e.g., size, symmetry, masses) • Testes (e.g., size, symmetry, masses) • Urethral meatus (e.g., size, location, lesions, discharge) • Penis (e.g., lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities) Digital rectal examination including: • Prostate gland (e.g., size, symmetry, nodularity, tenderness) • Seminal vesicles (e.g., symmetry, tenderness, masses, enlargement) • Sphincter tone, presence of hemorrhoids, or rectal masses
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

[42] HCFA, 1997, pp. 25-28

CPT Evaluation and Management, Physical Examination

Table V-B

Male Genitourinary Examination

Constitutional

- Vital Signs (3)
  - BP ↑/↓
  - BP →
  - Pulse RR
  - Respiration
  - Temp
  - Height
  - Weight
- General Appearance

Gastrointestinal

- Abd Exam: Mass/Tenderness
- Hernia Exam
- Liver & Spleen Exam
- Stool Occult (Indicated)

Lymphatic

- Palpate Lymph Nodes
  - Neck
  - Axillae
  - Groin
  - Other

GU Male

- Inspect Anus & Perineum

Genitalia Exam With/Without Specimen Collection:

- Scrotum
- Epididymides
- Testes
- Urethral Meatus
- Penis

Digital Rectal Exam Including:

- Prostate Gland
- Seminal Vesicles
- Sphincter Tone, Hemorrhoids & Rectal Masses

Skin

- Inspect & Palpate Skin & Sub-q Tissue

Neck

- Neck Exam
- Thyroid Exam

Respiratory

- Respiratory Effort
- Auscultation Lungs

Cardiovascular

- Auscultation Heart
- Peripheral Vascular Exam

Neuro/Psych

Brief MSE:

- Orientation Time, Place & Person
- Mood & Affect

Perform and Document:

Problem Focused: 1-5 bulleted (▪) elements.

Expanded Problem Focused: 6 or > bulleted (▪) elements.

Detailed: 12 or > bulleted (▪) elements.

Comprehensive: Perform all elements identified by a bullet (€); document all elements in each shaded box and at least 1 element in each unshaded box.

CPT Evaluation and Management, Physical Examination

Female Genitourinary Examination

The female genitourinary examination elements are found in Table VI-A. Table VI-B is a worksheet containing abbreviated female genitourinary physical examination elements.

Table VI-A[43]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus. • Examination of thyroid (e.g., enlargement, tenderness, or mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination for peripheral vascular system by observation (e.g., swelling or varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination for presence or absence of hernia • Examination of liver and spleen • Obtain stool sample for occult blood test when indicated
Genitourinary	**FEMALE:** Includes **at least seven (7) of the following eleven (11) elements:** • Inspection and palpation of breasts (e.g., masses or lumps, tenderness, symmetry, nipple discharge) • Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses Pelvic examination (with or without specimen collection for smears and cultures) including: • External genitalia (e.g., general appearance, hair distribution, lesions) • Urethral meatus (e.g., size, location, lesions, prolapse) • Urethra (e.g., masses, tenderness, scarring) • Bladder (e.g., fullness, masses, tenderness) • Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Cervix (e.g., general appearance, lesions, discharge) • Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent, support) • Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity) • Anus and perineum
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

[43] HCFA, 1997, pp. 25, 27-28

CPT Evaluation and Management, Physical Examination

Table VI-B

Female Genitourinary Examination

Constitutional

- Vital Signs (3)
  - BP ↑/↓
  - BP →
  - Pulse RR
  - Respiration
  - Temp
  - Height
  - Weight
- General Appearance

Gastrointestinal

- Abd Exam: Mass/Tenderness
- Hernia Exam
- Liver & Spleen Exam
- Stool Occult (Indicated)

Lymphatic

- Palpate Lymph Nodes
  - Neck
  - Axillae
  - Groin
  - Other

GU Female

Includes **at least 7** of the following 11 bulleted elements:

- Inspect & Palpate Breasts
- Digital Rectal Exam

Pelvic Exam With/Without Specimen Collection:

- External Genitalia
- Urethral Meatus
- Urethra
- Bladder
- Vagina
- Cervix
- Uterus
- Adnexa/Parametria
- Anus and Perineum

Skin

- Inspect & Palpate Skin & Sub-q Tissue

Neck

- Neck Exam
- Thyroid Exam

Respiratory

- Respiratory Effort
- Auscultation Lungs

Cardiovascular

- Auscultation Heart
- Peripheral Vascular Exam

Neuro/Psych

Brief MSE:

- Orientation Time, Place & Person
- Mood & Affect

Perform and Document:

Problem Focused: 1-5 bulleted (▪) elements.

Expanded Problem Focused: 6 or > bulleted (▪) elements.

Detailed: 12 or > bulleted (▪) elements.

Comprehensive: Perform all elements identified by a bullet (€); document all elements in each shaded box and at least 1 element in each unshaded box.

CPT Evaluation and Management, Physical Examination

Hematological/Lymphatic/Immunologic Examination

Documentation elements for the hematological/lymphatic/immunologic examination are found in Table VII-A. Table VII-B is a worksheet containing abbreviated hematological/lymphatic immunologic physical examination elements.

Table VII-A[44]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff.) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	• Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
Eyes	• Inspection of conjunctivae and lids
Ears, Nose, Mouth, and Throat	• Otoscopic examination of external auditory canals and tympanic membranes • Inspection of nasal mucosa, septum, and turbinates • Inspection of teeth and gums • Examination of oropharynx: (e.g. oral mucosa, hard and soft palates, tongue, tonsils, and posterior pharynx)
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Gastrointestinal/ Abdomen	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Extremities	• Inspection and palpation of digits, and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, ecchymoses, bruises)
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

[44] HCFA, 1997, pp. 29-30

CPT Evaluation and Management, Physical Examination

Table VII-B

Hematological/Lymphatic/Immunologic Examination

Constitutional
- Vital Signs (3)
  - BP ↑/↓
  - BP →
  - Pulse RR
  - Respiration
  - Temp
  - Height
  - Weight
- General Appearance

Gastrointestinal
- Abd Exam: Mass/Tenderness
- Liver & Spleen Exam

Lymphatic
- Palpate Lymph Nodes
  - Neck
  - Axillae
  - Groin
  - Other

Extremities
- Inspect & Palpate Digits & Nails

Cardiovascular
- Auscultation Heart
- Peripheral Vascular Exam

Respiratory
- Respiratory Effort
- Auscultation Lungs

ENMT
- Auditory Canal & Tympanic Membrane Exam
- Inspect Nasal Mucosa, Septum & Turbinates
- Inspect Teeth & Gums
- Oropharynx

Eyes
- Inspect Conjunctivae & Lids

Neck
- Neck Exam
- Thyroid Exam

Head and Face
- Palpate & Percussion Face

Neuro/Psych

Brief MSE:
- Orientation Time, Place & Person
- Mood & Affect

Skin
- Inspect & Palpate Skin & Sub-q Tissue

Perform and Document:

Problem Focused: 1-5 bulleted (▪) elements,

Expanded Problem Focused: 6 or > bulleted (▪) elements,

Detailed: 12 or > bulleted (▪) elements,

Comprehensive: Perform all elements identified by a bullet (€); document all elements in each shaded box and at least 1 element in each unshaded box.

CPT Evaluation and Management, Physical Examination

Musculoskeletal Examination

Documentation elements for the musculoskeletal examination are found in Table VIII-A. Table VIII-B is a worksheet containing abbreviated musculoskeletal physical examination elements.

Table VIII-A[45]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff.) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Cardiovascular	• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Musculoskeletal	• Examination of gait and station Examination of joint(s), bone(s), and muscles(s)/tendon(s) of **four (4) of the following six (6)** areas: (1) head and neck, (2) spine, ribs and pelvis, (3) right upper extremity, (4) left upper extremity, (5) right lower extremity, (6) left lower extremity. The examination of a given area includes: • Inspection, percussion, and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses, or effusions • Assessment range of motion with notation of pain (e.g., straight leg raising), crepitation, or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation, or laxity • Assessment of muscle strength and tone (e.g., flaccid, cogwheel, spastic) with notation of any atrophy or abnormal movements **NOTE**: For the comprehensive level of examination, all **four** (4) of the elements identified by a bullet must be performed and documented for **each** of **four** (4) anatomic areas. For the three (3) lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two (2) extremities constitutes two (2) elements.
Skin	• Inspection and/or palpation of skin and subcutaneous tissue e.g., scars, rashes, lesions, cafe-au-lait spots, or ulcers in **four (4) of the following six (6)** areas: (1) head and neck, (2) trunk, (3) right upper extremity, (4) left upper extremity, (5) right lower extremity (6) left lower extremity **NOTE:** For the comprehensive level, the examination of all four (4) anatomic areas must be preformed and documented. For the three (3) lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two (2) extremities constitutes two (2) elements.
Neurological/ Psychiatric	• Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, or evaluation of fine motor coordination in young children) • Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski) • Examination of sensation (e.g., by touch, pin, vibration, proprioception) Brief assessment of mental status including: • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

[45] HCFA, 1997, pp. 31-33

CPT Evaluation and Management, Physical Examination

Table VIII-B

Musculoskeletal Examination

Constitutional

- Vital Signs (3)
  - BP ↑/↓ Temp
  - BP → Height
  - Pulse RR Height
  - Respiration
- General Appearance

Cardiovascular

- Peripheral Vascular Exam

Musculoskeletal

- Gait & Station Exam

Examine Joint(s), Bone(s), Muscle(s), & Tendon(s) of 4 of 6 areas: 1) Head & Neck 2) Spine, Ribs & Pelvis 3) RUE 4) LUE 5) RLE 6) LLE

- Inspection, Percussion & Palpation
- Assess ROM
- Assess Stability
- Assess Muscle Strength & Tone

(Count each Area/Extremity Assessed)

Lymphatic

- Palpate Lymph Nodes
  - Neck
  - Axillae
  - Groin
  - Other

Skin

- Inspect & Palpate Skin & Sub-q Tissue

Neuro/Psych

- Test Coordination
- DTR Exam & Nerve Stretch Test
- Sensation Exam

Brief MSE:

- Orientation Time, Place & Person
- Mood & Affect

Perform and Document:

Problem Focused: 1-5 bulleted (▪) elements.

Expanded Problem Focused: 6 or > bulleted (▪) elements.

Detailed: 12 or > bulleted (▪) elements.

Comprehensive: Perform all elements identified by a bullet (€); document all elements in each shaded box and at least 1 element in each unshaded box.

CPT Evaluation and Management, Physical Examination

Neurological Examination

The neurological examination documentation elements are found in Table IX-A. Table IX-B is a worksheet containing abbreviated neurological physical examination elements.

Table IX-A[46]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff.) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
Cardiovascular	• Examination of carotid arteries (e.g., pulse amplitude, bruits) • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Musculoskeletal	• Examination of gait and station Assessment of motor function including: • Muscle strength in upper and lower extremities • Muscle tone in upper and lower extremities (e.g., flaccid, cogwheel, spastic) with notation of any atrophy, or abnormal movements (e.g., fasciculation, tardive dyskinesia)
Neurological	Evaluation of higher integrative functions including: • Orientation to time, place, and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases, spontaneous speech) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary) Test the following cranial nerves: • 2nd cranial nerve (e.g., visual acuity, visual fields, fundi) • 3rd, 4th, and 6th cranial nerves (e.g., pupils, eye movements) • 5th cranial nerve (e.g., facial sensation,corneal reflexes) • 7th cranial nerve (e.g., facial symmetry, strength) • 8th cranial nerve (e.g., hearing with tuning fork, whispered voice, and/or finger rub) • 9th cranial nerve (e.g., spontaneous or reflex palate movement) • 11th cranial nerve (e.g., shoulder shrug strength) • 12th cranial nerve (e.g., tongue protrusion) • Examination of sensation (e.g., by touch, pin, vibration, proprioception) • Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (e.g., Babinski) • Test coordination (e.g., finger/nose, heel/knee/shin, or rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

[46] HCFA, 1997, pp. 34-36

CPT Evaluation and Management, Physical Examination

Table IX-B

Neurological Examination

Constitutional

- Vital Signs (3)
  - BP ↑/↓
  - BP →
  - Pulse RR
  - Temp
  - Height
  - Weight
  - Respiration
- General Appearance

Eyes

- Optic Discs & Posterior Segment Exam

Musculoskeletal

- Gait & Station Exam
- Assess Muscle Strength
- Assess Muscle Tone

Cardiovascular

- Carotid Arteries
- Auscultation Heart
- Peripheral Vascular Exam

Neurological

- Orientation Time, Place & Person
- Recent & Remote Memory
- Attention Span & Concentration
- Language
- Fund of Knowledge
- Sensation Exam
- DTR Exam: Upper & Lower Extremities
- Test Coordination

Test Cranial Nerves:

- 2nd: Visual Acuity, Visual Fields, Fundi
- 3rd, 4th, 6th: Pupils, Eye Movement
- 5th: Facial Sensation, Corneal Reflexes
- 7th: Facial Symmetry, Strength
- 8th: Hearing with Tuning Fork, Whispered Voice & Finger Rub
- 9th: Spontaneous or Reflex Palate Movement
- 11th: Shoulder Shrug Strength
- 12th: Tongue Protrusion

Perform and Document:

Problem Focused: 1-5 bulleted (▪) elements.

Expanded Problem Focused: 6 or > bulleted (▪) elements.

Detailed: 12 or > bulleted (▪) elements.

Comprehensive: Perform all elements identified by a bullet (€); document all elements in each shaded box and at least 1 element in each unshaded box.

CPT Evaluation and Management, Physical Examination

Psychiatric Examination

The psychiatric examination documentation elements are found in Table X-A. Table X-B is a worksheet containing abbreviated psychiatric physical examination elements.

Table X-A[47]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff.) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Musculoskeletal	• Examination of gait and station • Assessment of muscle strength and tone (e.g., flaccid, cogwheel, spastic) with notation of any atrophy and/or abnormal movements
Psychiatric	• Description of speech: rate, volume, articulation, coherence, and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language) • Description of thought processes including: rate of thoughts or content of thoughts (e.g., logical vs. illogical, tangential; abstract reasoning; and computation) • Descriptions of associations (e.g., loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions • Description of the patient's judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) Complete mental status examination including: • Orientation to time, place, and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary) • Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability)

[47] HCFA, 1997 pp. 37-38

CPT Evaluation and Management, Physical Examination

Table X-B

<table>
<tr><th colspan="2">Psychiatric Examination</th></tr>
<tr><td><u>Constitutional</u>
• Vital Signs (3)
BP ↑/↓ Temp
BP → Height
Pulse RR Weight
Respiration
• General Appearance</td><td rowspan="2"><u>Psychiatric</u>
• Description of Speech
• Description of Thought Process
• Description of Associations
• Description of Abnormal/Psychotic Thoughts
• Description of Judgment
Brief MSE:
• Orientation Time, Place & Person
• Recent & Remote Memory
• Attention Span & Concentration
• Language
• Fund of Knowledge
• Mood & Affect</td></tr>
<tr><td><u>Musculoskeletal</u>
• Gait & Station Exam
• Assess Muscle Strength & Tone</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2"><u>Perform and Document:</u></td></tr>
<tr><td colspan="2">Problem Focused: 1-5 bulleted (•) elements.</td></tr>
<tr><td colspan="2">Expanded Problem Focused: 6 or > bulleted (•) elements.</td></tr>
<tr><td colspan="2">Detailed: 9 or > bulleted (•) elements.</td></tr>
<tr><td colspan="2">Comprehensive: Perform all elements identified by a bullet (€); document all elements in each shaded box and at least 1 element in each unshaded box.</td></tr>
</table>

CPT Evaluation and Management, Physical Examination

Respiratory Examination

The respiratory examination documentation elements are found in Table XI-A. Table XI-B is a worksheet containing abbreviated respiratory physical examination elements.

Table XI-A[48]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff.) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Ears, Nose, Mouth, and Throat	• Inspection of nasal mucosa, septum, and turbinates • Inspection of teeth and gums • Examination of oropharynx: (e.g., oral mucosa, hard and soft palates, tongue, tonsils, and posterior pharynx)
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass) • Examination of jugular veins (e.g., distension; a, v or cannon a waves)
Respiratory	• Inspection of chest with notation of symmetry and expansion • Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (e.g., dullness, flatness, hyperresonance) • Palpation of chest (e.g., tactile fremitus) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart including sounds, abnormal sounds, and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Gastrointestinal/ Abdomen	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Musculoskeletal	• Examination of gait and station • Assessment of muscle strength and tone (e.g., flaccid, cogwheel, spastic) with notation of any atrophy, and abnormal movements
Extremities	• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

[48] HCFA, 1997, pp. 39-40

CPT Evaluation and Management, Physical Examination

Table XI-B

Respiratory Examination

Constitutional

Vital Signs (3)

BP ↑/↓ Temp
BP → Height
Pulse RR Weight
Respiration

- General Appearance

ENMT

- Inspect Nasal Mucosa, Septum, & Turbinates
- Inspect Teeth & Gums
- Oropharynx Exam

Cardiovascular

- Auscultation Heart
- Peripheral Vascular Exam

Respiratory

- Chest Inspection
- Respiratory Effort
- Percussion Chest
- Palpation Chest
- Auscultation Lungs

Neck

- Neck Exam
- Thyroid Exam
- Jugular Vein Exam

Gastrointestinal

- Abd Exam: Mass/Tenderness
- Liver & Spleen Exam

Skin

- Inspect & Palpate Skin & Sub-q Tissue

Extremities

- Inspect & Palpate Digits & Nails

Musculoskeletal

- Gait & Station Exam
- Assess Muscle Strength & Tone

Neuro/Psych

Brief MSE:

- Orientation Time, Place & Person
- Mood & Affect

Lymphatic

- Palpate Lymph Nodes
  - Neck
  - Groin
  - Axillae
  - Other

Perform and Document:

Problem Focused: 1-5 bulleted (▪) elements.

Expanded Problem Focused: 6 or > bulleted (▪) elements.

Detailed: 12 or > bulleted (▪) elements.

Comprehensive: Perform all elements identified by a bullet (€); document all elements in each shaded box and at least 1 element in each unshaded box.

CPT Evaluation and Management, Physical Examination

Skin Examination

The skin examination documentation elements are found in Table XII-A. Table XII-B is a worksheet containing abbreviated skin physical examination elements.

Table XII-A[49]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three (3) of the following seven (7)** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (May be measured and recorded by ancillary staff.) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Inspection of conjunctivae and lids
Ears, Nose, Mouth, and Throat	• Inspection of lips, teeth, and gums • Examination of oropharynx: (e.g., oral mucosa, hard and soft palates, tongue, tonsils, and posterior pharynx)
Neck	• Examination of thyroid (e.g., enlargement, tenderness, mass)
Cardiovascular	• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Gastrointestinal/ Abdomen	• Examination of liver and spleen • Examination of anus for condyloma and other lesions
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Extremities	• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated), and extremities • Inspection and/or palpation of skin and subcutaneous tissue e.g., rashes, lesions, or ulcers and susceptibility to and presence of photo damage in **eight (8) of the following ten (10)** areas: (1) head, including the face (2) neck, (3) chest, including breast and axillae, (4) abdomen, (5) genitalia, groin, buttocks, (6) back, (7) right upper extremity, (8) left upper extremity, (9) right lower extremity and/or (10) left lower extremity **NOTE**: For the comprehensive level, the examination of at least eight (8) anatomic areas must be performed and documented. For the three (3) lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and the left upper extremity constitute two (2) elements. • Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses, or bromhidrosis
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

[49] HCFA, 1997, pp. 41-42

CPT Evaluation and Management, Physical Examination

Table XII-B

Skin Examination

Constitutional
- Vital Signs (3)
  - BP ↑/↓ Temp
  - BP → Height
  - Pulse RR Weight
  - Respiration
- General Appearance

Cardiovascular
- Peripheral Vascular Exam

Skin
- Palpate Scalp & Inspect Hair of Scalp, Eyebrows, Face, Chest, Pubic Area & Extremities
- Palpate & Inspect Skin & Sub-q Tissue in 8 of 10 areas:
- Head, including Face
- Neck
- Chest, including Breasts, Axillae
- Abdomen
- Genitalia, Groin, Buttocks
- Back
- RUE
- LUE
- RLE
- LLE
- Inspect Eccrine & Apocrine Glands of Skin and Sub-q Tissue

Eyes
- Inspect Conjunctivae & Lids

Lymphatic
- Palpate Lymph Nodes
  - Neck
  - Groin
  - Axillae
  - Other

ENMT
- Inspect Lips, Teeth & Gums
- Oropharynx Exam

Extremities
- Inspect & Palpate Digits & Nails

Gastrointestinal
- Liver & Spleen Exam
- Anus: Condyloma, Lesions

Neck
- Thyroid Exam

Neuro/Psych

Brief MSE:
- Orientation Time, Place & Person
- Mood & Affect

Perform and Document:

Problem Focused: 1-5 bulleted (•) elements.

Expanded Problem Focused: 6 or > bulleted (•) elements.

Detailed: 12 or > bulleted (•) elements.

Comprehensive: Perform all elements identified by a bullet (€); document all elements in each shaded box and at least 1 element in each unshaded box.

Physical Examination Practice Outpatient Service Scenarios

The following cases, A, B, and C, are provided as exercises for applying the information contained in the Physical Examination section.

Patient A:

Patient A is a 42 year old male who is seen for the first time in the Family Practice clinic with a laceration and abrasions of the right upper arm. The injury occurred during renovation of an old building. A board with nails fell from a beam and grazed the right arm. The wound was oozing blood after the incident occurred. The arm was tightly wrapped with a towel at the scene.

The patient history is negative – no medications and no past surgeries.

Allergies: Sulfa
Vital Signs: BP – 124/78, P – 56, T – 37.8

Upon arrival at the clinic, the patient appears in no distress. The wound involves the subcutaneous tissue layer, and is 3cm in length. Edges are jagged. No bleeding noted on examination.

KEY	**DOCUMENTATION**
Patient Type/Category	Shaded
Patient History	Underlined

Physical Examination Practice Outpatient Service Scenarios (Continued)

Patient A – Physical Examination Worksheet

What is the level of physical examination? Select the elements documented on the physical examination portion of the worksheet. Then indicate the level of physical examination e.g., problem focused, expanded problem focused in the last column.

Patient History

✔ **Chief Complaint** | ✔ **New Patient** | - **Established Patient**

To qualify for a given type of history, all three elements (HPI, ROS, PFSH) in the table must be met.

HPI	ROS	PFSH	Type of History
✔ Location - Quality ✔ Severity - Duration - Timing ✔ Context - Mod Factor ✔ Assoc S&S	✔ Allergic/Imm - Constitutional - Hem/Lymph - ENMT ✔ Integument - Eyes - GI - GU - CV - Endocrine - Musc/Skel - Neurological - Psychiatric - Respiratory	✔ Past History - Family History - Social History	Documentation of history of present illness, review of systems, and past, family and/or social history establishes the *type of history*.
- Brief HPI = 1-3			**- Problem Focused**
- Brief HPI = 1-3	**- Problem Pertinent ROS = Related System**		**- Expanded Problem Focused**
✔ Extended HPI = 4 or >/3 Chr	**✔ Extended ROS = 2-9 Systems**	**✔ Pertinent PFSH = 1**	**✔ Detailed**
- Extended HPI = 4 or >/3 Chr	**- Complete ROS = 10 or > Systems**	**- Complete = 2-3**	**- Comprehensive**

General Multi-System Examination

Constitutional
- Vital Signs (3)
  - BP ↑/↓
  - BP →
  - Pulse RR
  - Respiration
  - Temp
  - Height
  - Weight
- General Appearance

Gastrointestinal
- Abd Exam: Mass/Tenderness
- Liver & Spleen Exam
- Hernia Exam
- Anus, Perineum & Rectum Exam
- Stool Occult (Indicated)

ENMT
- Inspect External Ears & Nose
- Aud Canal & Tymp Membr Exam
- Assess Hearing
- Inspect Nasal Mucosa, Sept & Turb
- Inspect Lips, Teeth & Gums
- Oropharynx Exam

Cardiovascular
- Palpation Heart
- Auscultation Heart
- Carotid Arteries
- Abdominal Aorta
- Femoral Arteries
- Pedal Pulses
- Extremities

Respiratory
- Respiratory Effort
- Percussion Chest
- Palpation Chest
- Auscultation Lungs

Skin
- Inspect Skin & Sub-q Tiss
- Palpate Skin & Sub-q Tiss

Lymphatic
- Palp Lymph Nodes 2 or >
  - Neck
  - Axillae
  - Groin
  - Other

Neurological
- Test Cranial Nerves
- DTR Exam
- Sensation Exam

Eyes
- Insp Conjunc & Lids
- Pupil & Iris Exam
- Optic Disc Exam

Genitourinary

Male	Female	
- Scrotum	- Genitalia	- Cervix
- Penis	- Urethra	- Uterus
- Prostate	- Bladder	- Adnexa

Musculoskeletal
- Gait & Station
- Inpect/Palp Digits & Nails
- Joints, Bones & Muscles 1 or > of 6 areas
  - Inspect/Palpate
  - Stability
  - ROM
  - Musc Strength & Tone

Psychiatric
- Judgement & Insight
- Memory
- Orientation TPP
- Mood & Affect

Neck
- Neck Exam
- Thyroid Exam

Chest/Breast
- Inspect Breasts
- Palp Breast & Axilla

Type of Examination Perform and Document:

- **Problem Focused: 1-5 bulleted (•) elements**
- **Expanded Problem Focused: 6 or > bulleted (•) elements**
- **Detailed: 2 or > bulleted (•) elements of 6 systems or 12 or > bulleted (•) elements in 2 or > systems**
- **Comprehensive: Perform all elements identified by a bullet (•) in at least 9 organ systems/body areas and document at least 2 bulleted (•) elements from each of 9 systems/areas**

Physical Examination Scenarios (Continued)

Patient B:

Patient B is an 8 year old female who was recently seen in the Pediatric clinic with tonsillitis. Returns today for follow-up visit. Feeling better. Denies sore throat. Occasional nonproductive cough. Denies nausea, vomiting, or diarrhea.

Patient medical history is positive for frequent URIs. No surgeries. Family history negative.
Lives with mother, father, and three siblings. Has missed 10 days of school.
Current Medications: Sudafed, Amoxicillin
Allergies: None
Vital Signs: BP – 86/54, P – 100, R – 24, T – 37.8, Wt – 23kg, Ht – 108cm

Exam: Color improved. Alert and oriented x3; Ears: tympanic membranes: clear; Throat: tonsils, slight atrophy without inflammation; Mouth: mucous membranes moist; no nasal drainage; Neck: no masses; Chest: clear; CV: regular without murmur; Abdomen: no masses/tenderness, liver/spleen normal.

KEY	**DOCUMENTATION**
Patient Type/Category	Shaded
Patient History	Underlined

CPT Evaluation and Management, Physical Examination

Physical Examination Scenarios (Continued)

Patient B – Physical Examination Worksheet

What is the level of physical examination? Select the elements documented on the physical examination portion of the worksheet. Then indicate the level of physical examination e.g., problem focused, expanded problem focused in the last column.

Patient History

✔ **Chief Complaint** ✔ **New Patient** - **Established Patient**

To qualify for a given type of history, all three elements (HPI, ROS, PFSH) in the table must be met.

HPI	ROS	PFSH	Type of History
✔ Location - Quality ✔ Severity - Duration - Timing - Context - Mod Factor ✔ Assoc S&S	✔ Allergic/Imm - Constitutional - Hem/Lymph ✔ ENMT - Integument - Eyes ✔ GI - GU - CV - Endocrine - Musc/Skel - Neurological - Psychiatric ✔ Respiratory	✔ Past History ✔ Family History ✔ Social History	Documentation of history of present illness, review of systems, and past, family and/or social history establishes the *type of history*.
- **Brief HPI = 1-3**			- **Problem Focused**
✔ **Brief HPI = 1-3**	- **Problem Pertinent ROS = Related System**		✔ **Expanded Problem Focused**
- **Extended HPI = 4 or >/3 Chr**	✔ **Extended ROS = 2-9 Systems**	- **Pertinent PFSH = 1**	- **Detailed**
- **Extended HPI = 4 or >/3 Chr**	- **Complete ROS = 10 or > Systems**	✔ **Complete = 2-3**	- **Comprehensive**

General Multi-System Examination

Constitutional
- Vital Signs (3)
  - BP ↑/↓
  - BP →
  - Pulse RR
  - Respiration
  - Temp
  - Height
  - Weight
- General Appearance

Gastrointestinal
- Abd Exam: Mass/Tenderness
- Liver & Spleen Exam
- Hernia Exam
- Anus, Perineum & Rectum Exam
- Stool Occult (Indicated)

ENMT
- Inspect External Ears & Nose
- Aud Canal & Tymp Membr Exam
- Assess Hearing
- Inspect Nasal Mucosa, Sept & Turb
- Inspect Lips, Teeth & Gums
- Oropharynx Exam

Cardiovascular
- Palpation Heart
- Auscultation Heart
- Carotid Arteries
- Abdominal Aorta
- Femoral Arteries
- Pedal Pulses
- Extremities

Respiratory
- Respiratory Effort
- Percussion Chest
- Palpation Chest
- Auscultation Lungs

Skin
- Inspect Skin & Sub-q Tiss
- Palpate Skin & Sub-q Tiss

Lymphatic
- Palp Lymph Nodes 2 or >
  - Neck
  - Groin
  - Axillae
  - Other

Neurological
- Test Cranial Nerves
- DTR Exam
- Sensation Exam

Genitourinary

Male
- Scrotum
- Penis
- Prostate

Female
- Genitalia
- Urethra
- Bladder
- Cervix
- Uterus
- Adnexa

Musculoskeletal
- Gait & Station
- Inpect/Palp Digits & Nails
- Joints, Bones & Muscles 1 or > of 6 areas
  - Inspect/Palpate
  - Stability
  - ROM
  - Musc Strength & Tone

Psychiatric
- Judgement & Insight
- Memory
- Orientation TPP
- Mood & Affect

Neck
- Neck Exam
- Thyroid Exam

Eyes
- Insp Conjunc & Lids
- Pupil & Iris Exam
- Optic Disc Exam

Chest/Breast
- Inspect Breasts
- Palp Breast & Axilla

Type of Examination
Perform and Document:

- **Problem Focused: 1-5 bulleted (•) elements**
- **Expanded Problem Focused: 6 or > bulleted (•) elements**
- **Detailed: 2 or > bulleted (•) elements of 6 systems or 12 or > bulleted (•) elements in 2 or > systems**
- **Comprehensive: Perform all elements identified by a bullet (•) in at least 9 organ systems/body areas and document at least 2 bulleted (•) elements from each of 9 systems/areas**

CPT Evaluation and Management, Physical Examination

Physical Examination Practice Outpatient Service Scenarios (Continued)

Patient C:

Cardiology Office Visit: The primary care provider requested a cardiology consultation for evaluation and/or management of congestive heart failure. The patient was seen yesterday by the primary care provider. Patient C is a new patient to the Cardiology clinic. The EKG showed atrial fibrillation and the chest x-ray indicated congestive heart failure. Laboratory results are being faxed to the office.

Patient C is a new patient to the Cardiology clinic. He is a 62 year old male with a new onset of congestive heart failure.

Chief Complaint: Patient referred with recent findings of CHF. Experiencing shortness of breath and palpitations. Symptoms are precipitated by mowing lawn or with walking approximately five (5) blocks. Denies chest pain.

History: No personal or family history of CAD, MI, or CA.
Surgeries include lap cholecystectomy 10 years ago. On no medication.
Occasional alcohol, has not smoked for 8 years.

Allergies: Penicillin
Vital Signs: BP – R130/86, L134/86, P – 120, R – 24, T – 37.0, Weight – 65kg, Height – 150cm

Exam: Appears older than stated age, retired. CV: pulse irregular rhythm, no murmur, faint bilateral rales. Neck: carotid – no bruit, no JVD. Abdomen: no masses/tenderness, liver/spleen wnl. Extremities: Femoral pulses strong, equal; Bilateral pedal pulses faint. 1+ ankle edema. Decreased exercise tolerance.

KEY	**DOCUMENTATION**
Patient Type/Category	Shaded
Patient History	Underlined

Continue to the next page for the physical examination worksheet. Two physical examination worksheets are provided for this sample case. The first work sheet is for the multi-system body examination, and the second worksheet contains the cardiovascular body system examination. The objective is to apply the body system elements that will result in the higher level of physical examination.

CPT Evaluation and Management, Physical Examination

Physical Examination Practice Outpatient Service Scenarios (Continued)

Patient C – Physical Examination Worksheet

What is the level of physical examination? Select the elements documented on the physical examination portion of the worksheet. Then indicate the level of physical examination in the last column.

Patient History

✔ Chief Complaint ✔ New Patient - Established Patient

To qualify for a given type of history, all three elements (HPI, ROS, PFSH) in the table must be met.

HPI	ROS	PFSH	Type of History
✔ Location ✔ Timing - Quality - Context - Severity ✔ Mod Factor ✔ Duration ✔ Assoc S&S	✔ Allergic/Imm - Eyes - Musc/Skel - Constitutional - GI - Neurological - Hem/Lymph - GU - Psychiatric - ENMT ✔ CV ✔ Respiratory - Integument - Endocrine	✔ Past History ✔ Family History ✔ Social History	Documentation of history of present illness, review of systems, and past, family and/or social history establishes the *type of history*.
- Brief HPI = 1-3			- Problem Focused
- Brief HPI = 1-3	- Problem Pertinent ROS = Related System		- Expanded Problem Focused
✔ Extended HPI = 4 or >/3 Chr	✔ Extended ROS = 2-9 Systems	- Pertinent PFSH = 1	✔ Detailed
- Extended HPI = 4 or >/3 Chr	- Complete ROS = 10 or > Systems	✔ Complete = 2-3	- Comprehensive

General Multi-System Examination

Constitutional
- Vital Signs (3)
  - BP ↑/↓ Temp
  - BP → Height
  - Pulse RR Weight
  - Respiration
- General Appearance

Gastrointestinal
- Abd Exam: Mass/Tenderness
- Liver & Spleen Exam
- Hernia Exam
- Anus, Perineum & Rectum Exam
- Stool Occult (Indicated)

ENMT
- Inspect External Ears & Nose
- Aud Canal & Tymp Membr Exam
- Assess Hearing
- Inspect Nasal Mucosa, Sept & Turb
- Inspect Lips, Teeth & Gums
- Oropharynx Exam

Cardiovascular
- Palpation Heart
- Auscultation Heart
- Carotid Arteries
- Abdominal Aorta
- Femoral Arteries
- Pedal Pulses
- Extremities

Respiratory
- Respiratory Effort
- Percussion Chest
- Palpation Chest
- Auscultation Lungs

Skin
- Inspect Skin & Sub-q Tiss
- Palpate Skin & Sub-q Tiss

Lymphatic
- Palp Lymph Nodes 2 or >
  - Neck • Groin
  - Axillae • Other

Neurological
- Test Cranial Nerves
- DTR Exam
- Sensation Exam

Genitourinary

Male	Female
- Scrotum	- Genitalia - Cervix
- Penis	- Urethra - Uterus
- Prostate	- Bladder - Adnexa

Musculoskeletal
- Gait & Station - Inpect/Palp Digits & Nails
- Joints, Bones & Muscles 1 or > of 6 areas
  - Inspect/Palpate • Stability
  - ROM • Musc Strength & Tone

Psychiatric
- Judgement & Insight - Memory
- Orientation TPP - Mood & Affect

Neck
- Neck Exam
- Thyroid Exam

Eyes
- Insp Conjunc & Lids
- Pupil & Iris Exam
- Optic Disc Exam

Chest/Breast
- Inspect Breasts
- Palp Breast & Axilla

Type of Examination
Perform and Document:

- Problem Focused: 1-5 bulleted (€) elements
- Expanded Problem Focused: 6 or > bulleted (€) elements
- Detailed: 2 or > bulleted (€) elements of 6 systems or 12 or > bulleted (€) elements in 2 or > systems
- Comprehensive: Perform all elements identified by a bullet (€) in at least 9 organ systems/body areas and document at least 2 bulleted (€) elements from each of 9 systems/areas

Cardiovascular Examination

Constitutional
- Vital Signs (3)
  - BP ↑/↓ Temp
  - BP → Height
  - Pulse RR Weight
  - Respiration
- General Appearance

Gastrointestinal
- Abd Exam: Mass/Tenderness
- Liver & Spleen Exam
- Stool Occult (Indicated)

ENMT
- Inspect Teeth, Gums & Palate
- Inspect Oral Mucosa
  Note Pallor/Cyanosis

Cardiovascular
- Palpation Heart
- Auscultation Heart
- BP 2 or > Extremities
- Carotid Arteries
- Abdominal Aorta
- Femoral Arteries
- Pedal Pulses
- Extremities: Peripheral Edema & Varicosities

Musculoskeletal
- Back Exam: Kyphosis/Scoliosis
- Examine Gait/Ability to Exercise
- Assess Muscle Strength & Tone

Eyes
- Inspect Conjunctive & Lids

Respiratory
- Respiratory Effort
- Auscultation Lungs

Extremities
- Inspect & Palpate Digits & Nails

Neck
- Jugular Vein Exam
- Thyroid Exam

Skin
- Inspect & Palpate Skin & Sub-q Tissue

Neuro/Psych
Brief MSE:
- Orientation Time, Place & Person
- Mood & Affect

Type of Examination

Perform and Document:

- Problem Focused: 1-5 bulleted (-) elements
- Expanded Problem Focused: 6 or > bulleted (-) elements
- Detailed: 12 or > bulleted (-) elements
- Comprehensive: Perform all elements identified by a bullet (-), document all elements in a box with a border and 1 element in each box with no border.

CPT Evaluation and Management, Physical Examination

Physical Examination Answers

Text addressing the Physical Examination is ***bold/italics***.

Patient A:

Patient A is a 42 year old male who is seen for the first time in the Family Practice clinic with a laceration and abrasions of the right upper arm. The injury occurred during renovation of an old building. A board with nails fell from a beam and grazed the right arm. The wound was oozing blood after the incident occurred. The arm was tightly wrapped with a towel at the scene.

The patient history is negative – no medications and no past surgeries.

Allergies: Sulfa
Vital Signs: BP – 124/78, P – 56, T – 37.8

The patient ***appears in no distress***. The wound ***involves the subcutaneous tissue layer, and is 3cm in length***. ***Edges are jagged***. ***No bleeding noted on examination.***

KEY	**DOCUMENTATION**
Patient Type/Category	Shaded
Patient History	Underlined
Patient Physical Examination	***Bold/Italics***

CPT Evaluation and Management, Physical Examination

Physical Examination Answers (Continued)

Patient A – Physical Examination Worksheet

Patient History

✔ **Chief Complaint** ✔ **New Patient** - **Established Patient**

To qualify for a given type of history, all three elements (HPI, ROS, PFSH) in the table must be met.

HPI	ROS	PFSH	Type of History
✔ Location - Quality ✔ Severity - Duration - Timing ✔ Context - Mod Factor ✔ Assoc S&S	✔ Allergic/Imm - Constitutional - Hem/Lymph - ENMT ✔ Integument - Eyes - GI - GU - CV - Endocrine - Musc/Skel - Neurological - Psychiatric - Respiratory	✔ Past History - Family History - Social History	Documentation of history of present illness, review of systems, and past, family and/or social history establishes the *type of history*.
- Brief HPI = 1-3			**- Problem Focused**
- Brief HPI = 1-3	**- Problem Pertinent ROS = Related System**		**- Expanded Problem Focused**
✔ Extended HPI = 4 or >/3 Chr	**✔ Extended ROS = 2-9 Systems**	**✔ Pertinent PFSH = 1**	**✔ Detailed**
- Extended HPI = 4 or >/3 Chr	**- Complete ROS = 10 or > Systems**	**- Complete = 2-3**	**- Comprehensive**

General Multi-System Examination

Constitutional
- Vital Signs (3)
  - BP ↑/↓
  - BP →
  - Pulse RR
  - Respiration
  - Temp
  - Height
  - Weight
- ✔ General Appearance

Gastrointestinal
- Abd Exam: Mass/Tenderness
- Liver & Spleen Exam
- Hernia Exam
- Anus, Perineum & Rectum Exam
- Stool Occult (Indicated)

ENMT
- Inspect External Ears & Nose
- Aud Canal & Tymp Membr Exam
- Assess Hearing
- Inspect Nasal Mucosa, Sept & Turb
- Inspect Lips, Teeth & Gums
- Oropharynx Exam

Cardiovascular
- Palpation Heart
- Auscultation Heart
- Carotid Arteries
- Abdominal Aorta
- Femoral Arteries
- Pedal Pulses
- Extremities

Respiratory
- Respiratory Effort
- Percussion Chest
- Palpation Chest
- Auscultation Lungs

Skin
- ✔ Inspect Skin & Sub-q Tiss
- ✔ Palpate Skin & Sub-q Tiss

Lymphatic
- Palp Lymph Nodes 2 or >
  - Neck
  - Axillae
  - Groin
  - Other

Neurological
- Test Cranial Nerves
- DTR Exam
- Sensation Exam

Eyes
- Insp Conjunc & Lids
- Pupil & Iris Exam
- Optic Disc Exam

Genitourinary

Male
- Scrotum
- Penis
- Prostate

Female
- Genitalia
- Urethra
- Bladder
- Cervix
- Uterus
- Adnexa

Musculoskeletal
- Gait & Station
- Inpect/Palp Digits & Nails
- Joints, Bones & Muscles 1 or > of 6 areas
  - Inspect/Palpate
  - ROM
  - Stability
  - Musc Strength & Tone

Psychiatric
- Judgement & Insight
- Orientation TPP
- Memory
- Mood & Affect

Neck
- Neck Exam
- Thyroid Exam

Chest/Breast
- Inspect Breasts
- Palp Breast & Axilla

Type of Examination

Perform and Document:

✔ **Problem Focused: 1-5 bulleted (€) elements**

- Expanded Problem Focused: 6 or > bulleted (€) elements

- Detailed: 2 or > bulleted (€) elements of 6 systems or 12 or > bulleted (€) elements in 2 or > systems

- Comprehensive: Perform all elements identified by a bullet (€) in at least 9 organ systems/body areas and document at least 2 bulleted (€) elements from each of 9 systems/areas

Physical Examination Answers (Continued)

Text addressing the Physical Examination is ***bold/italics***.

Patient B:

Patient B is an 8 year old female who was recently seen in the Pediatric clinic with tonsillitis. Returns today for follow-up visit. Feeling better. Denies sore throat. Occasional nonproductive cough. Denies nausea, vomiting, or diarrhea.

Patient medical history is positive for frequent URIs. No surgeries. Family history negative.
Lives with mother, father, and three siblings. Has missed 10 days of school.
Current Medications: Sudafed, Amoxicillin
Allergies: None
Vital Signs: BP – 86/54, P – 100, R – 24, T – 37.8, Wt – 23kg, Ht – 108cm

Exam: ***Color improved***. ***Alert and oriented x3***; ***Ears: Tympanic Membranes: clear***; ***Throat: tonsils, slight atrophy without inflammation***; ***Mouth: mucous membranes moist; no nasal drainage; Neck: no masses***; ***Chest: clear***; ***CV: regular without murmur***; ***Abdomen: no masses/tenderness, liver/spleen normal***.

KEY	**DOCUMENTATION**
Patient Type/Category	Shaded
Patient History	Underlined
Patient Physical Examination	***Bold/Italics***

CPT Evaluation and Management, Physical Examination

Physical Examination Answers (Continued)

Patient B – Physical Examination Worksheet

Patient History

✔ **Chief Complaint** ✔ **New Patient** - **Established Patient**

To qualify for a given type of history, all three elements (HPI, ROS, PFSH) in the table must be met.

HPI	ROS	PFSH	Type of History
✔ Location - Timing - Quality - Context ✔ Severity - Mod Factor - Duration ✔ Assoc S&S	✔ Allergic/Imm - Eyes - Musc/Skel - Constitutional ✔ GI - Neurological - Hem/Lymph - GU - Psychiatric ✔ ENMT - CV ✔ Respiratory - Integument - Endocrine	✔ Past History ✔ Family History ✔ Social History	Documentation of history of present illness, review of systems, and past, family and/or social history establishes the *type of history*.
- **Brief HPI = 1-3**			- **Problem Focused**
- **Brief HPI = 1-3**	- **Problem Pertinent ROS = Related System**		✔ **Expanded Problem Focused**
✔ **Extended HPI = 4 or >/3 Chr**	✔ **Extended ROS = 2-9 Systems**	- **Pertinent PFSH = 1**	- **Detailed**
- **Extended HPI = 4 or >/3 Chr**	- **Complete ROS = 10 or > Systems**	✔ **Complete = 2-3**	- **Comprehensive**

General Multi-System Examination

Constitutional
✔ Vital Signs (3)
BP ↑/↓ Temp
BP → Height
Pulse RR Weight
Respiration
✔ General Appearance

Gastrointestinal
✔ Abd Exam: Mass/Tenderness
✔ Liver & Spleen Exam
- Hernia Exam
- Anus, Perineum & Rectum Exam
- Stool Occult (Indicated)

ENMT
✔ Inspect External Ears & Nose
✔ Aud Canal & Tymp Membr Exam
- Assess Hearing
✔ Inspect Nasal Mucosa, Sept & Turb
- Inspect Lips, Teeth & Gums
✔ Oropharynx Exam

Cardiovascular
- Palpation Heart
✔ Auscultation Heart
- Carotid Arteries
- Abdominal Aorta
- Femoral Arteries
- Pedal Pulses
- Extremities

Respiratory
- Respiratory Effort
- Percussion Chest
- Palpation Chest
✔ Auscultation Lungs

Skin
- Inspect Skin & Sub-q Tiss
- Palpate Skin & Sub-q Tiss

Lymphatic
- Palp Lymph Nodes 2 or >
• Neck • Groin
• Axillae • Other

Neurological
- Test Cranial Nerves
- DTR Exam
- Sensation Exam

Genitourinary

Male	Female	
- Scrotum	- Genitalia	- Cervix
- Penis	- Urethra	- Uterus
- Prostate	- Bladder	- Adnexa

Musculoskeletal
- Gait & Station - Inpect/Palp Digits & Nails
- Joints, Bones & Muscles 1 or > of 6 areas
• Inspect/Palpate • Stability
• ROM • Musc Strength & Tone

Psychiatric
- Judgement & Insight - Memory
✔ Orientation TPP - Mood & Affect

Neck
✔ Neck Exam
- Thyroid Exam

Chest/Breast
- Inspect Breasts
- Palp Breast & Axilla

Eyes
- Insp Conjunc & Lids
- Pupil & Iris Exam
- Optic Disc Exam

Type of Examination
Perform and Document:

- **Problem Focused: 1-5 bulleted (€) elements**

- **Expanded Problem Focused: 6 or > bulleted (€) elements**

✔ **Detailed: 2 or > bulleted (€) elements of 6 systems or 12 or > bulleted (€) elements in 2 or > systems**

- **Comprehensive: Perform all elements identified by a bullet (€) in at least 9 organ systems/body areas and document at least 2 bulleted (€) elements from each of 9 systems/areas**

Physical Examination Answers (Continued)

Text addressing the Physical Examination is ***bold/italics***.

Patient C:

Cardiology Office Visit: The primary care provider requested a cardiology consultation for evaluation and/or management of congestive heart failure. The patient was seen yesterday by the primary care provider. Patient C is a new patient to the Cardiology clinic. The EKG showed atrial fibrillation and the chest x-ray indicated congestive heart failure. Laboratory results are being faxed to the office.

Patient C is a new patient to the Cardiology clinic. He is a 62 year old male with a new onset of congestive heart failure.

Chief Complaint: Patient referred with recent findings of CHF. Experiencing shortness of breath and palpitations. Symptoms are precipitated by mowing lawn or with walking approximately five (5) blocks. Denies chest pain.

History: No personal or family history of CAD, MI, or CA.
Surgeries include lap cholecystectomy 10 years ago. On no medication.
Occasional alcohol, has not smoked for 8 years.

Allergies: Penicillin
Vital Signs: BP – R130/86, L134/86, P – 120, R – 24, T – 37.0, Weight – 65kg, Height – 150cm

Exam: ***Appears older than stated age***, retired. ***CV: pulse irregular rhythm, no murmur, faint bilateral rales. Neck: carotid – no bruit, no JVD. Abdomen: no masses/tenderness, liver/spleen wnl. Extremities: Femoral pulses strong, equal; Bilateral pedal pulses faint. 1+ ankle edema. Decreased exercise tolerance.***

KEY	**DOCUMENTATION**
Patient Type/Category	Shaded
Patient History	Underlined
Patient Physical Examination	***Bold/Italics***

CPT Evaluation and Management, Physical Examination

Physical Examination Answers (Continued)

Patient C – Physical Examination Worksheet

Patient History

✔ **Chief Complaint** ✔ **New Patient** - **Established Patient**

To qualify for a given type of history, all three elements (HPI, ROS, PFSH) in the table must be met.

HPI	ROS	PFSH	Type of History
✔ Location ✔ Timing - Quality - Context - Severity ✔ Mod Factor ✔ Duration ✔ Assoc S&S	✔ Allergic/Imm - Eyes - Musc/Skel - Constitutional - GI - Neurological - Hem/Lymph - GU - Psychiatric - ENMT ✔ CV ✔ Respiratory - Integument - Endocrine	✔ Past History ✔ Family History ✔ Social History	Documentation of history of present illness, review of systems, and past, family and/or social history establishes the *type of history*.
- **Brief HPI = 1-3**			- **Problem Focused**
- **Brief HPI = 1-3**	- **Problem Pertinent ROS = Related System**		- **Expanded Problem Focused**
✔ **Extended HPI = 4 or >/3 Chr**	✔ **Extended ROS = 2-9 Systems**	- **Pertinent PFSH = 1**	✔ **Detailed**
- **Extended HPI = 4 or >/3 Chr**	- **Complete ROS = 10 or > Systems**	✔ **Complete = 2-3**	- **Comprehensive**

General Multi-System Examination

Constitutional
✔ Vital Signs (3)
BP ↑/↓ Temp
BP → Height
Pulse RR Weight
Respiration
✔ General Appearance

Gastrointestinal
✔ Abd Exam: Mass/Tenderness
✔ Liver & Spleen Exam
- Hernia Exam
- Anus, Perineum & Rectum Exam
- Stool Occult (Indicated)

ENMT
- Inspect External Ears & Nose
- Aud Canal & Tymp Membr Exam
- Assess Hearing
- Inspect Nasal Mucosa, Sept & Turb
- Inspect Lips, Teeth & Gums
- Oropharynx Exam

Cardiovascular
- Palpation Heart
✔ Auscultation Heart
✔ Carotid Arteries
- Abdominal Aorta
✔ Femoral Arteries
✔ Pedal Pulses
✔ Extremities

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Male	Female	
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- Prostate	- Bladder	- Adnexa

Musculoskeletal
- Gait & Station - Inpect/Palp Digits & Nails
- Joints, Bones & Muscles 1 or > of 6 areas
• Inspect/Palpate • Stability
• ROM • Musc Strength & Tone

Psychiatric
- Judgement & Insight - Memory
- Orientation TPP - Mood & Affect

Neck
✔ Neck Exam
- Thyroid Exam

Eyes
- Insp Conjunc & Lids
- Pupil & Iris Exam
- Optic Disc Exam

Chest/Breast
- Inspect Breasts
- Palp Breast & Axilla

Type of Examination
Perform and Document:

- **Problem Focused: 1-5 bulleted (€) elements**

✔ **Expanded Problem Focused: 6 or > bulleted (€) elements**

- **Detailed: 2 or > bulleted (€) elements of 6 systems or 12 or > bulleted (€) elements in 2 or > systems**

- **Comprehensive: Perform all elements identified by a bullet (€) in at least 9 organ systems/body areas and document at least 2 bulleted (€) elements from each of 9 systems/areas**

Cardiovascular Examination

Constitutional
✔ Vital Signs (3)
BP ↑/↓ Temp
BP → Height
Pulse RR Weight
Respiration
✔ General Appearance

Gastrointestinal
✔ Abd Exam: Mass/Tenderness
✔ Liver & Spleen Exam
- Stool Occult (Indicated)

ENMT
- Inspect Teeth, Gums & Palate
- Inspect Oral Mucosa
Note Pallor/Cyanosis

Cardiovascular
- Palpation Heart
✔ Auscultation Heart
✔ BP 2 or > Extremities
✔ Carotid Arteries
- Abdominal Aorta
✔ Femoral Arteries
✔ Pedal Pulses
✔ Extremities: Peripheral Edema & Varicosities

Musculoskeletal
- Back Exam: Kyphosis/Scoliosis
✔ Examine Gait/Ability to Exercise
- Assess Muscle Strength & Tone

Eyes
- Inspect Conjunctive & Lids

Respiratory
- Respiratory Effort
✔ Auscultation Lungs

Extremities
- Inspect & Palpate Digits & Nails

Neck
✔ Jugular Vein Exam
- Thyroid Exam

Skin
- Inspect & Palpate Skin & Sub-q Tissue

Neuro/Psych
Brief MSE:
- Orientation Time, Place & Person
- Mood & Affect

Type of Examination
Perform and Document:

- **Problem Focused: 1-5 bulleted (-) elements**

- **Expanded Problem Focused: 6 or > bulleted (-) elements**

✔ **Detailed: 12 or > bulleted (-) elements**

- **Comprehensive: Perform all elements identified by a bullet (-), document all elements in a box with a border and 1 element in each box with no border.**

Two (2) physical examination worksheets were provided for this sample case: general multi-system and cardiovascular. The objective was to apply the body system that would result in the higher level of physical examination. The cardiovascular examination resulted in the higher level of examination (Detailed).